# A NONTRADITIONAL CANCER TREATMENT PROGRAM AND PASTORAL CARE: A WHITEHEADIAN PERSPECTIVE

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by

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## ABSTRACT

Since cancer is the second ranking fatal disease in the United States and one in six die from cancer, few families are exempt from this disease. Very little attention has been given to the emotional and psychological factors involved in treating cancer patients. Traditional methods of treatment have been surgery, radiation therapy, and chemotherapy. Stress and host resistance are believed to be correlated and this has been demonstrated in animal experimentation.

A visualization technique is used by Carl and Stephanie Simonton in Fort Worth, Texas, primarily to reduce stress and restore the body's natural ability to ward off disease through the immune system. This practice along with group meetings and intensive psychotherapy can have the effect of emotional catharsis, achievement of valuable personality insights, and motivating people to live. If psychological stress depresses immune activity, stress reduction could restore the body's ability to overcome invading viruses in those cases where cancer is the result of a virus, or generally to attack the foreign cells of the cancer.

The belief system of the patient is an important aspect in the course the body takes during and after treatment. The Simontons discovered a high correlation between

a positive attitude and positive response to treatment. Cancer patients see themselves as victims of the disease and have negative feelings about treatment. They see themselves as not having participated in the development of cancer that they see as an outside agent acting in the body, and they can do nothing personally to help themselves get well.

Those involved in pastoral care are likewise concerned about the belief system of cancer patients. In addition to those negative beliefs noted by the Simontons, patients frequently have feelings of guilt. They interpret their suffering as divine punishment for sins. Their theology increases the unhealthy state of mind. The Whiteheadian-process theology position can be used to avoid this negative interpretation. Process theology holds that divine causality is persuasive and not compulsive. God is not the only efficient cause of any event but one of many influences. Each actuality has some power for self-determination, and thus power to choose how to respond to the various efficient causes, including God. A person's beliefs and attitudes play an important part in the way God can causally affect him. The person who does not believe in God will tend to be unreceptive to divine influence. Process theology supports the view that God is on the patient's side, that there is a divine healing power with which he can cooperate.

Process theology holds that God desires healthy cells that enjoy themselves and contribute to the enjoyment of the body and mind of the human being. It is suggested that occasional divine intervention is not the manner in which God relates. The pastor's role in this healing process is to help people find a positive health-giving belief system, one that unites, rather than separates, people from God.

# Chapter 1

## INTRODUCTION

Cancer is the second-ranking fatal disease in the United States, causing one of every six deaths. It is perhaps the most feared of all diseases and frequently the options for treatment are more dreaded than the disease itself. Surgical techniques, radiotherapy, intricate chemotherapeutic regimens, and promising immunotherapeutic models have recently become accepted as treatment procedures for malignancies. People over 45 are more prone to cancer--the number of deaths for persons under 45 is 25,000 annually. Between 45 and 55 the death rate is 40,000, between 65 and 74 it is 90,000, and for people 85 and older it drops to 20,000.[1]

The role of the pastor in dealing with cancer patients has been clouded by medical practices, beliefs, and expectations. A major emphasis has been in preparing for death while overlooking the possibility of revival and new life. The mental, emotional, and spiritual fall within the realm of pastoral care. The study proposes a model for the pastor in which he takes an active part in dealing with the mental and emotional needs of the cancer patient.

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[1]Kenneth R. Pelletier, Mind as Healer, Mind as Slayer (New York: Dell, 1977), pp. 173-174.

Leslie Weatherhead suggested the Church must return to a more active participation in caring for the sick.

> In spite of the reign of science, the Church must be called back to the ministry of intercession for the sick. In the same sentence, we read that Christ sent His men out to "preach the Kingdom of God and to heal the sick." We have done the former, but the latter we have almost entirely handed over to the medical profession. The doctors have done magnificent work, but they cannot do all the work.[2]

## BACKGROUND OF THE PROBLEM

No organ or tissue is safe from cancer and some areas are more susceptible than others. The most frequently affected areas are the mouth, skin, respiratory organs, blood and lymph systems, digestive organs, urinary system, genitals, and breasts in women. The lungs and digestive tract seem to be more vulnerable in men while cancer is more common in the breasts, digestive tract, and cervix in women. Cancer assumes many forms including Hodgkin's disease, various leukemias that are common in children, and various forms of solid tumors. Cancer is a complex family of diseases having in common the degeneration of the normal reproductive activity of cells. Progress of cancer seems to be related to a breakdown in the body's own protective system, the auto-immune system. Unregulated cell growth in the form of expanding tumors creates

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[2]Leslie D. Weatherhead, Psychology, Religion and Healing (New York: Abingdon Press, 1952), p. 247.

pressure on adjoining cells and organs interfering with their normal activity, leading to further breakdowns and greedy absorption of cellular nutrients. Danger increases as this malignant activity spreads to other areas. When growths are localized they may be more easily treated or surgically removed. When the mutant cells move into the blood or lymphatic system and spread to other parts of the body they are impossible to treat or control by traditional methods.[3]

Much research has been done in efforts to discover what causes cells to mutate and become cancerous. Mutation involves a change in the genetic material of the normal cell. Each cell has a specific genetic code contained in the DNA of the cell nucleus which it passes on to succeeding cells to determine their structure and function. When material containing the code is altered the result is change in the cell developed to replace the original cell. It is currently theorized that cancerous mutations are common but the immune systems usually destroy them before they multiply. The implication is that there is danger only when immune systems fail to eliminate mutant cells. A number of agents have been demonstrated to contribute to the growth of cancerous tumors if immune systems fail to be effective. An early theory by Percival Pott, a

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[3]Pelletier, pp. 174-175.

London physician who lived in the eighteenth century, related the high rate of scrotal cancer among chimney sweeps to a carcinogenic (cancer-inducing) agent in the soot. Since then many carcinogenic agents have been discovered, such as excessive exposure to radiation, certain industrial dyes, chemicals in automobile exhausts, industrial smog, trauma, burns, and cigarette smoke. There is also some evidence for hereditary predisposition in some types of cancer including cancer of the breast in women. The risk of breast cancer in daughters of a patient with breast cancer is five times that of the general population.[4]

Much effort recently has been focused on the role of viruses, the smallest and least complex organisms known. A virus can survive for years in a dormant state without air or nourishment and without reproducing. They cause a host of common illnesses. Under stressful conditions viruses seem to become active and behave like parasites by invading the cells where they reproduce. The cells eventually burst and are destroyed while the viruses move on to other cells. A dozen viruses have been established as possible causes of cancer in animals. Research is impeded by the great difficulty in following the progress of viruses within the cell. In one type of rabbit tumor viruses cannot be detected when growing most actively and are observable only in old cells

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[4]Ibid., pp. 175-176.

when damage has been done. In normal viral infections viruses are easily detected under an electron microscope as the illness reaches its peak. Some researchers have speculated that by the time the cancerous tumor develops the virus loses its identity by merging with the nucleic acids of the invaded cell. Other scientists think there may be no specific cancer-producing viruses but that any virus can invade a cell and cause it to become cancerous. The difference between normal viral infection and cancer-producing virus is that the normal virus does not invade the nucleus but reproduces in the cell plasma. In cancer, the virus attacks the cell nucleus which contains DNA molecules and the genetic code, thus altering genetic material which in turn affects subsequent replication of the cell.[5]

An important discovery was made in June 1974 by researchers Charles McGrath and Marvin Rich of the Michigan Cancer Foundation when they isolated a human virus implicated in breast cancer. This was followed by the work of Robert E. Gallagher and Robert C. Gallo of the National Cancer Institute who isolated a human virus associated with acute myelocytic leukemia. This type of tumor accounts for less than 1 percent of human tumors but it was a significant contribution to understanding cancer causation.

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[5]Ibid., pp. 176-177.

Research in animal-tumor viruses has been more productive with implications for more in-depth human research.[6]

Some research has investigated the role of stress in tumor incidence in animals. Research has been done in this area by Vernon Riley of the Fred Hutchinson Research Center in Seattle, Washington. He subjected experimental mice to a variety of stresses such as isolation or overcrowding after being weaned from mothers known to bear mammary-tumor viruses. Incidence of mammary-tumor could be increased to 90 percent under stress while remaining at 7 percent in a protected environment. Regarding this research Riley stated:

> The data suggest that moderate chronic or intermittent stress may predispose such mice to an increased risk of mammary carcinoma, possibly through a resultant compromise of their immunological competence or tumor surveillance system, and that adequate protection from physiological stress may reduce mammary tumor occurrence in mice.[7]

It has been established that prolonged periods of stress tend to weaken immune systems and thus increase susceptibility to viral as well as other infections. It is also known that during prolonged stress the number of T-lymphocytes and eosinophil cells in the blood decrease markedly. The function of these cells is to seek out and destroy foreign antigens, therefore their reduction in numbers during stress may increase vulnerability to cancer

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[6]Ibid., p. 177. [7]Ibid.

patients but the relationship is not necessarily causative; they may be an effect of the disease.[8]

The central nervous system may also be involved in stress-related aspects of cancer, in that abnormal nervous patterns may damage control mechanisms. Mutant cells may be permitted to multiply undetected. Information perceived by the cerebrocortical levels of the brain and emotional activity in the hypothalamic area are directly related to nervous system functions. It is therefore possible that emotionally induced nervous responses may contribute to the development of cancer. Pelletier made the following significant and positive statements regarding psychosocial stress factors:

> If psychosocial stress factors, acting upon the immune system, can induce cancer, then there is the further possibility that this negative process can be reversed and immunity established or enhanced through stress-reduction practices. Events which trigger a negative trend toward psychosomatic disorders are not necessarily of major magnitude. Methods of altering this progression do not have to be of a large magnitude either. At early stages of the disease process, subtle but critical interventions could alter the balance from pathology to health.[9]

## PURPOSE OF THE STUDY

The major objective of the study is to consider a holistic approach in treatment of cancer patients and more specifically, to study one nontraditional cancer treatment

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[8]Ibid., pp. 178-179. [9]Ibid., p. 181.

program. Since traditional methods of treatment have frequently proven inadequate and ineffective in producing cures, other approaches to treatment and prevention of cancer should be studied. One of these approaches is described in Chapter 3.

The study surveys research studies made to determine psychological factors involved in onset and development of tumors. Pastoral care involves dealing with the emotional and spiritual. The purpose of the study is thus to seek ways the pastor can become more actively involved in dealing with attitudes and beliefs of cancer patients. Negative beliefs about God can cause feelings of guilt that contribute to stress and affect the onset and outcome of the disease. The pastor is equipped to deal with guilt and negative beliefs. The study stresses the importance of positive theological interpretations of illness.

## THEORETICAL FORMULATION

The study was done within the theoretical framework of Whiteheadian process philosophy or philosophy of organism. The common-sense approach to existence has been a dualism involving mind and body. Understanding the relationship between mind and body is of vital importance generally, and particularly when considering diseases such as cancer. Cartesian dualism has been one answer to the mind-body problem. Descartes believed there were three substances--

mind, matter, and God. He defined substance as "an existent thing which requires nothing but itself in order to exist."[10] The created substances, corporeal or thinking, need only the "concurrence of God in order to exist."[11] Whitehead rejected Cartesian dualism. He said, "In modern philosophy Descartes' two kinds of substance, corporeal and mental, illustrate incoherence,"[12] and he further referred to Descartes' "disastrous classification of substances into two species, bodily substance and mental substance."[13]

Whitehead saw the world as a process of becoming "actual entities" or "actual occasions."[14] These enduring entities are momentary experiences and in the strictest sense individuals are experience rather than having experience.[15] Life implies a certain absoluteness of self-enjoyment arising out of the process of appropriating into the unity of existence the many data presented. This process of appropriation is called "prehension" or

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[10]Alfred N. Whitehead, Religion in the Making (New York: New American Library, 1960), p. 102.

[11]Ibid., p. 103.

[12]Alfred N. Whitehead, Process and Reality (New York: Free Press, 1969), p. 9.

[13]Ibid., p. 90. [14]Ibid., p. 27.

[15]David R. Griffin, "Pan-experientialism and Problems of Evil, Epiphenomenalism, Evolution, Ecology and Evangelism" (Address delivered at the School of Theology at Claremont, 1973), p. 4.

perception. Each individual act of immediate enjoyment is an "occasion of experience."[16] Actual entities are experiences and thus subjects. There is no dualism between things which are subjects and those which are objects as with Descartes, therefore the "problem of the relation between the 'mind' and the 'body' is not in principle insoluble."[17]

The doctrine of pan-experientialism is helpful in defining the relationship between the mind and body. This does not mean everything experiences. According to Whitehead, only individuals experience, and genuine individuals are electrons, atoms, molecules, animal psyches, and God. Aggregates such as rocks and trees have no experience--only the individual cells and molecules within them experience. Not all experience is conscious experience. Only higher forms such as animal psyches have conscious experience. Whitehead's term "prehension" refers to perception that could be unconscious as well as conscious.[18]

The problem of suffering or nonmoral evil is considered in the study from a Whiteheadian and process

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[16]Alfred N. Whitehead, Modes of Thought (New York: Free Press, 1968), pp. 150-151.

[17]David R. Griffin, "Whitehead's Contributions to a Theology of Nature," Bucknell Review, XX, 3 (Winter 1972), 6.

[18]Griffin, "Pan-experientialism . . .," p. 3.

theology perspective. If divine causation is total then all evil must be considered as being willed by God. Somehow, in human suffering, God's goodness and wisdom is expressed. Traditional theism solved this problem by denying the existence of evil in the world. What appeared to be evil was ultimately a means to good and thus not genuinely evil. God as Controlling Power is responsible for every detail and therefore for all apparent evil, according to this view.[19]

The question of why there is so much suffering in the world is raised. If God is perfectly good and all powerful, why is suffering permitted, and especially so much suffering? Victims of disease and certainly cancer patients often ask the question, why me? What have I done to deserve this punishment? Why does God permit this condition to exist? Why does God not intervene and wipe out this cause of so much suffering in human beings? These questions are answered from a Whiteheadian and process theology perspective.

## SCOPE OF THE STUDY

The study describes the cancer treatment program of Carl and Stephanie Simonton in which traditional methods

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[19]John B. Cobb, Jr. and David R. Griffin, Process Theology (Philadelphia: Westminster Press, 1976), pp. 69-74.

and highly innovative methods using psychotherapy and visualization are combined. The importance of attitude and belief upon development and treatment of cancer is emphasized in the Simonton program. Those involved in pastoral care have also noted the importance of attitude upon physical health. The study describes positive and negative theological belief systems.

## METHODOLOGY

The research method used in the study was a descriptive analysis and interpretation of data available in the area of nontraditional methods in cancer treatment. The data were integrated with Whiteheadian process philosophy and process theology. The data considered were from a broad and definitive selection of scholarly research.

## ORGANIZATION OF THE REMAINDER OF THE STUDY

Chapter 2 deals with the psychological factors involved in the onset of cancer. Very little has been done in the past to treat cancer patients from the standpoint of emotional and psychological factors. Achterberg, Simonton, and Simonton clearly pointed this out:

> It was stated in 1952, after Eugene Blumberg did his initial work correlating cancer growth rates in man with psychological factors, that this information would dramatically alter the approach to the cancer patient. Twenty-four years later, no apparent change in the emotional care of the cancer patient has transpired. It is our sincere hope that this publication

> will have some effect on altering the approach to the cancer patient, such that psychological factors are considered and addressed directly; also that an overt attempt to stimulate the patient's will to live is made as a routine part of approaching the cancer problem in every patient.[20]

The holistic approach to health implies that human beings are mind, body, and spirit. Illness is not simply a malfunction of a part which requires treatment. When one entity of the human being is out of focus or adjustment it is a sign of breakdown elsewhere and affects the entire person. Chapter 3 describes the cancer treatment program of Carl and Stephanie Simonton in Fort Worth, Texas. Chapter 4 deals with the psychodynamics of illness and pastoral care. The role of the pastor in counseling with cancer patients is considered. This role must not be relegated to the exclusive function of preparing the patient for death. Stress, attitudes, and emotions are important factors in the development and course of malignancies, including recovery. Chapter 5 describes the mind-body problem and the problem of nonmoral evil or suffering from a Whiteheadian-process theology perspective. Chapter 6 presents a brief summary of the study.

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[20]Jeanne Achterberg, O. Carl Simonton, and Stephanie Matthews-Simonton (eds.), Stress, Psychological Factors, and Cancer (Fort Worth, TX: New Medicine Press, 1976), p. 8.

# Chapter 2

## PSYCHOLOGICAL FACTORS INVOLVED IN ONSET OF CANCER

In 1952, the same year in which Blumberg published the results of his initial work correlating cancer growth rates with psychological factors (see Chapter 1), Weatherhead wrote the following:

> It is the writer's conviction that a good deal of what is now thought to be organic disease, solely caused by physical factors, will be found to be ultimately caused by emotional factors deep in the mind. . . . This may even be true of some of the killing diseases, like coronary thrombosis, tuberculosis and cancer. They may turn out to be physical concomitants of psychological, and even spiritual, disharmony.[1]

## STRESS AND IMMUNITY

The relationship between stress and host resistance is clearly defined in the literature, especially in animal experimentation. Conclusive evidence has been presented that prolonged or intense stress predisposes an animal to the development of malignancy and significantly influences the course of the disease. The following studies are cited by Achterberg, Simonton, and Simonton. By varying stress conditions Riley demonstrated that he could alter the incidence of breast cancer in mice from 90 percent under

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[1]Leslie D. Weatherhead, Psychology, Religion and Healing (New York: Abingdon Press, 1952), p. 500.

stressful conditions to 7 percent in a protected environment. In a study dealing with emotions, stress, and immunity, Solomon and Amkraut concluded that the significant factors in host resistance relating to malignancy are the immune system and hormonal balance. Lesions in the dorsal hypothalamus in rabbits resulted in suppression of the immune system with decreased antibody production and retention of antigen while electrical stimulation to the same area led to enhanced antibody response. Prehn also drew the same conclusion that host resistance is a significant factor in tumor development and this is mediated through immunological reactions and hormonal balance. He further agreed that stress reactions mediated through the hypothalamus can cause hormonal and immunological deficiencies that permit malignancies to develop. Holmes developed a scale for rating stressful events and associating these with onset and seriousness of illness, including cancer. He found a positive relationship between seriousness of illness and magnitude of life-changes. This approach reinforces the work of the other authors, suggesting there is a relationship between intense stress and host resistance, and thus creating a situation in which illness can develop.[2]

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[2]Jeanne Achterberg, O. Carl Simonton, and Stephanie Matthews-Simonton (eds.), Stress, Psychological Factors, and Cancer (Fort Worth, TX: New Medicine Press, 1976), pp. 10-11.

## INADEQUATE DISCHARGE OF EMOTIONS

An article by Brown et al. dealt with the relationship between cancer and mental states and suggested some common causal factors. Follow-up studies of patients treated for a variety of neuroses showed a high number developed malignant disease after receiving treatment for their affective illness and the death rates in this group of patients was significantly higher than the predicted national death rates. In depression and depressive illnesses the death rate was disproportionately high. The authors postulated there is a common relationship between depression, depressive illnesses, and carcinoma, and that these depressive illnesses have an effect on the immune system. The authors pointed out that during the eighteenth and nineteenth centuries many writers cited depression following loss of a loved object or person as a significant factor in the development of malignancy. Cancer patients have frequently experienced loss of significant figures through death and have had a tendency toward hopelessness and despair when facing loss and grief. Other characteristics mentioned were domination by the mother, immature sexual adjustment, inability to express hostility, and inability to accept the loss of a significant object, that all predated the onset of cancer. Certain psychological characteristics that predate cancer symptoms

are common among cancer patients. These characteristics are reflected in an inhibited life style, the inability to grieve loss, in depression, and in poor emotional outlets.[3]

In 1954, Blumberg conducted a study to investigate the possible relationship of emotional factors on fast and slow growing tumors. The Minnesota Multiphasic Personality Inventory (MMPI) test results obtained from 50 patients diagnosed as having inoperable tumors indicated statistically significant differences between the fast and slow tumor group. Those patients with fast growing tumors showed high levels of defensiveness, the need to appear good, and the need to present a front of being less disturbed than they really were. Emotional conflicts produced more tension in this group and they could not adequately defend themselves against anxiety. Tensions could not be successfully reduced through action. These results were used to predict medical classification and proved to be correct in 78 percent of the 25 subjects evaluated. The use of the Rorschach corroborated the findings of the MMPI and showed the slow growing tumor group evidenced a greater ability to absorb emotional shocks as well as the ability to reduce tension by motor discharge. Both groups studied appeared to have

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[3]J. H. Brown et al., "Psychiatry and Oncology: A Review," Journal of the Canadian Psychiatric Association, XIX, 2 (1974), 219-222.

an ambitious striving beyond their personal resources that may have produced severe frustration.[4]

The studies by Brown et al. and Blumberg provide evidence that cancer patients lack the ability to discharge emotions in healthy ways. They appear to be overwhelmed by grief situations as well as frustration producing experiences, and respond with efforts to present a front showing over-control and lack of emotional expression.

## PERSONALITY CHARACTERISTICS

An important and frequently-asked question is whether there is sufficient information about predisposing psychological factors to malignancy to predict any one individual's potentiality to cancer. "The answer is yes, there is no doubt enough information available to pinpoint certain high-risk individuals."[5]

### Life History Patterns of Cancer Patients

LeShan conducted a 12 year research project in which he studied 450 adult cancer patients. The Worthington Personal History test was used and interviews were adapted to cancer patients to include general medical history, vocation,

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[4]Achterberg, Simonton and Matthews-Simonton, pp. 25-26.

[5]Ibid., p. 20.

marital status, and family history. A general life history pattern was formulated that included the following life events. Damage to the child's development occurred during the first seven years of life and this interfered with his ability to relate. Certain physical events, such as loss of parent or death of a sibling accentuated this damage. The child felt he was at fault in these experiences and guilt and self-condemnation were his responses to these experiences. Each person did have a period during which he experienced enjoyment but this gradually changed and life was characterized by failure. A sense of a series of failures leads to feelings of hopelessness. Seventy-two percent of the cancer patients experienced this pattern compared to 10 percent of the controls. The study further revealed that the cancer patients experienced a crucial loss of a major relationship prior to signs of malignancy. Cancer mortality rates were compared in different marital classes and it was found that mortality rates varied in the following descending order: widowed, divorced, married, and single. LeShan felt these rates showed the greatest to least loss. Some individuals with the cancer characteristic life pattern do not develop cancer while there are some who possess these patterns and do develop cancer; that suggests a genetic factor may be at work. LeShan concluded there are psychological factors that appear statistically more often than in controls and these characteristics are in

existence before the first symptoms of malignancy are noted.[6]

Caroline Thomas and Karen Duszynski conducted a study on closeness to parents in 1,337 medical students who graduated from Johns Hopkins School of Medicine between 1948 and 1964. The researchers discovered that those who later developed malignant tumors perceived a lack of closeness to parents.[7]

Klopfer used the Rorschach (ink blot) test to test his theory of the symbiotic relationship between the cancer patient and his cancer. His work was stimulated by reports that some cancer patients seem to live longer and more comfortably than other patients and he attempted to identify the psychological factors involved in slow or fast tumor growth. He found that the slow growing tumor group was characterized by a nonchalant attitude toward reality and low ego defensiveness. The fast tumor group were those who tried hard to be loyal to reality and who invested too much ego defensive energy in attempts to be good and loyal. Klopfer suggested if too much vital energy is used in defense of an insecure ego, insufficient energy is left

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[6]L. L. LeShan, "An Emotional Life-History Pattern Associated with Neoplastic Disease," Annals of the New York Academy of Sciences, CXXV (1966), 780-793.

[7]Kenneth R. Pelletier, Mind as Healer, Mind as Slayer (New York: Dell, 1977), p. 142.

to fight off cancer. On the other hand, if a minimum amount of energy is used in defensiveness, the cancer process will be inhibited. He cited several studies in which the type of tumor was predicted with 70-80 percent accuracy with knowledge only of the age and sex of the patient.[8]

Pelletier pointed out that the cancer patients frequently compensate by trying to please everyone. They are characterized by anger, loneliness, and self-hatred. Later in life they are described as fine, gentle, thoughtful, uncomplaining people. But underneath are feelings of unworthiness and self-hatred. They have bottled-up hostility and possess a martyr-like quality.[9]

Types of Malignancies and Psychological Patterns

It is important to note that cancer is not merely one disease but a wide variety of diseases which have certain common aspects. Lymphoma cells differ from breast cancer cells and it might be assumed that the psychological characteristics of these patients also differ. The research in associating psychological patterns with different types of malignancy is sketchy because of the difficulty in gaining access to oncology patients and the resistance and suspicions aroused in the patients themselves when

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[8]Achterberg, Simonton and Matthews-Simonton, p. 27.

[9]Pelletier, p. 135.

asked to participate in lengthy testing procedures.[10]

In a study by Kissen the possibility was explored that inhaling habits of lung cancer patients might reveal certain features of personality that would shed light on the finding that non-inhaling heavy smokers seem to show a greater risk of lung cancer than inhaling smokers. It was also noted that some light smokers develop lung cancer while some heavy smokers do not. The Maudsley Personality Inventory was used to test the hypothesis that one basic personality characteristic of the lung cancer patient is a poor outlet for emotional discharge. The results showed that inhaling lung cancer patients had poor emotional discharge while non-inhaling lung cancer patients had the poorest of all. It was concluded from the results of the study that the poorer the ability to discharge emotions, the less smoke is needed to produce lung cancer. Non-inhalation may be associated with inability to express emotions. This contention is supported by the observation that non-smokers who develop lung cancer have the poorest outlet for emotional discharge of all those studied.[11]

Greene reported on studies conducted over a 15 year period, dealing with the social and psychological experiences of patients developing leukemia and lymphoma.

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[10]Achterberg, Simonton and Matthews-Simonton, p. 42.

[11]Ibid., pp. 43-44.

His first observations were of 16 male patients who experienced emotional loss experiences through the death of a mother figure such as the wife or the mother herself. In addition, all of these patients were adjusting to other losses such as loss of self-esteem related to injury, retirement, or change of work. A second study of 32 female patients showed that 30 of these had experienced significant emotional distress related to interpersonal separations such as death or threat of death of mother, menopause, and change of home. In another series of studies involving over 100 patients it was demonstrated that leukemia or lymphoma developed in an environmental setting in which the patient had dealt with a number of losses or separations. These losses were accompanied by feelings of sadness, anxiety, anger, or hopelessness.[12]

Wheeler and Caldwell reported the psychological test results of their study of women with cancer of the breast, cancer of the cervix, and without cancer. The results of the study indicated the women with cervical cancer are less controlled in their sensual emotional responsiveness to external stimulation than the other two groups. They also appeared to be more occupied with the ideation of sex and the body than the other women tested. The cervix patients reported more frequently

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[12]Ibid., pp. 45-46.

having unsuccessful fathers, as well as less love and attention as children than the breast cancer patients and the controls. Childhood deprivation seemed to be more characteristic of the women with cervical cancer. The breast cancer group appeared to have a more normal childhood environment than the cervix group, although there was the suggestion that the mother-daughter ties were closer than in the other two groups. This group, however, exhibited less "inner-drive" and appeared to overgeneralize on a variety of subjects.[13]

Bacon, Renneker, and Cutler investigated the existence of a cancer personality in relation to breast cancer. The major behavioral characteristics they studied included inhibited sexuality; inhibited motherhood; inability to deal appropriately with anger, aggression, or hostility; the unresolved mother conflict; and delay in securing treatment. Many of the women in the study did delay taking action in seeking a physician following the appearance of a lump. This may have been the result of poor education but this appeared unlikely to the researchers. The women in the study showed a higher tendency toward sexual inhibition and frustration than did neurotic women. The breast cancer patients were more likely to be childless and those who did have children showed excessive mothering.

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[13]Ibid., pp. 46-47.

Most of the women had abnormal relations with their own mothers that were described as a sense of extreme obligation to the mother. Of the group of 40 patients studied, 35 had masochistic tendencies. They were all excessively pleasant and could not deal appropriately with anger. The guilt feelings, delay in treatment, and masochistic character are suggestions of an internalized self-destructive drive and may be seen as a form of passive suicide.[14]

## SUMMARY

Clinicians are still far from understanding how personality and emotional factors influence the onset and course of cancer but a pattern is emerging. It is difficult to define a specific personality configuration which correlates directly with cancer. There are a wide variety of emotional conditions. Some elements tend to recur consistently, such as the "despair" syndrome noted by LeShan--the hopeless state in which the individual experiences a sense of unrelatedness to everything around him.

> LeShan (1961) and others have summed up their statistical and clinical research as follows:
> 1. there seems to be a correlation between cancer and certain types of psychological situations;
> 2. the most consistently reported psychological finding has been the loss of a major emotional relationship prior to the first symptoms of the tumor;
> 3. there appears to be some relationship between personality organization and the length of time between

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[14]Ibid., pp. 48-49.

> a traumatic event in the life of the patients and the appearance of a neoplasm; and also there may be some relationship between personality organization and the type or location of a cancer.[15]

These observations do not imply inevitable progression of the disease. This kind of research has a note of optimism--psychosocial and personality factors can be changed to promote healing.

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[15]Pelletier, pp. 143-144.

# Chapter 3

## A NONTRADITIONAL APPROACH TO CANCER PATIENT CARE

This chapter describes one nontraditional approach to care of cancer patients. The conventional medical treatment has been surgery, radiation therapy, and chemotherapy, generally in that order. Any approach, therefore, other than these three could be considered nontraditional in the sense that it is not widely accepted.

### REVIEW OF PROGRAM FOR CARE OF CANCER PATIENTS BY CARL AND STEPHANIE SIMONTON

One of the most innovative approaches to self-healing by the use of visualization has been made by Carl Simonton, radiation oncologist, and his wife, Stephanie, in Fort Worth, Texas. There is considerable evidence that shows this procedure can be used to slough off the effects of prolonged stress and restore the body's natural ability to ward off disease through the immune system. Pelletier described visualization as "the summoning and holding of certain images in the mind for examination and exploration of their effects on consciousness."[1] The process involves visualizing images, colors, abstract concepts, selective

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[1]Kenneth R. Pelletier, Mind as Healer, Mind as Slayer (New York: Dell, 1977), p. 244.

states of feeling, and other persons. Repressed material often surfaces and it can enable extensive emotional catharsis with achievement of valuable personality insights. In a stage of passive concentration it can be a powerful tool to mobilize resources of body and mind.

> Where the mind tends to focus, the emotions and the physiology are likely to follow. Despite the fact that the link between visualization and neurophysiological alterations remains an enigma, there is increasing evidence that subtle mental phenomena can have a profound positive or negative impact upon an individual's entire psychophysiology. Exploring the potential of this impact is one of the most stimulating areas at the frontiers of holistic approaches to healing.[2]

The Simontons have examined psychosocial factors of cancer and the means of altering these in a positive direction. Their work is the first to show these psychosocial factors can be influenced by stress reduction and visualization techniques. There has been some skepticism among their colleagues because cancer has not been widely acknowledged to have a psychosomatic origin. But as the role of viruses in cancer is becoming known, failure of an over-stressed immune system to maintain surveillance over viruses appears to be the primary factor in cancer onset and treatment. Psychologic stress has been shown to depress immune activity, thus stress reduction could be one means of restoring the body's ability to overcome

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[2]Ibid., p. 251.

invasiv viruses.

> Life is suspended in a delicate balance, and whatever benefits might be derived from stress-reduction techniques and psychosocial counseling should be considered in a holistic approach to the cancer patient.[3]

Carl Simonton began to develop his approach to cancer in 1969 after hearing a prominent immunologist advance the still relatively unaccepted theory that cancer is due to breakdown in the body's immune system. The immunologist had achieved a high rate of remission with leukemic patients by applying a concentrated solution of the patient's abnormal white cells to a prepared area of skin with hopes of evoking an immune response that would encourage the body's defenses to attack the foreign cells. Other researchers tried to duplicate these results but the positive outcome was cut in half. Simonton began to suspect the higher success rates in the initial experiments was due to the patients' full knowledge and understanding of the potential treatment, along with the excitement, enthusiasm, and belief among the patients and the doctor.

Pursuing this observation, Simonton began to study histories of the 2 to 5 percent of patients with metastic cancer who had an unexpectedly good response to treatment in an effort to discover a common denominator that might help to explain their recoveries. The single factor he

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[3]Ibid., p. 253.

noted quickly was the patients' attitude. There was a high correlation between positive attitudes and positive response to treatment. But the prospect of changing attitudes was not promising, especially when patients were severely depressed. Simonton noted that control of blood pressure, peripheral temperature, and other processes could be achieved during the relaxed state, and he postulated that it might be possible to influence immune mechanisms. He evolved a treatment based on belief-system modification.

By the middle of 1971, Simonton evolved this unique treatment for use with cancer patients referred to him for radiology treatment. The first patient was a 61 year old man with widespread throat cancer who had lost weight, could not eat, and could barely swallow. The diagnosis was that the condition was incurable by radiation therapy. Simonton combined radiation and meditative techniques. Visualization involved picturing the destruction of cancerous material by the body's immunological system. After three months' treatment, the patient recovered completely. The patient also overcame arthritis and impotence by a modification of the visualization technique. There have been other dramatic outcomes with other therapeutic techniques but the significance of the results in this case was that a new approach had been successful. "The success with this patient was an indication of a new direction, a method of focusing

upon and rectifying the psychosocial factors of neoplastic disease."[4]

Shortly after this initial case, Simonton went into the Air Force and the commanding officer at Travis Air Force Base in California was receptive to this innovative approach. He treated numerous cases with this new approach and significant outcomes were obtained.[5]

Pelletier pointed out that this approach to the care of cancer patients should not be used as a substitute for traditional treatment methods.

> Once again it must be emphasized it is of utmost importance to bear in mind that the application of meditative and visualization techniques is an adjunct to traditional treatment and is not proffered as an alternative. Furthermore, these stress-reduction approaches are only one aspect of a lengthy screening process and intensive psychotherapy sessions, with the visualization used primarily as homework exercises to keep the patient involved in the healing process.[6]

The major conclusion reached by Carl and Stephanie Simonton in the development of their approach to cancer treatment is that psychological factors--mental and emotional states--play a significant role in the development of malignancy and the course of the disease. They pointed out that there are some misconceptions about their treatment program. They do not have all the answers; not all patients get well; they are not satisfied with the results; and they have a long way to go. The Simontons are appalled that the

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[4]Ibid., p. 255. [5]Ibid., p. 256. [6]Ibid., p. 259.

vast majority of cancer treatment centers are ignoring any psychological intervention in the care of cancer patients, especially since the research has indicated a relationship between psychological factors and cancer for many years. In 1956, Blumberg related tumor growth rates and progress of the disease to psychological testing. With 80 percent accuracy he predicted growth rates on the basis of MMPI results without seeing the patients. Art Schmale, in Rochester, New York, could predict with 70 percent accuracy whether a questionable pap smear was malignant. In a longitudinal study involving 1,000 medical students at Johns Hopkins, which began in the 1940's, it was discovered there were common psychological parameters for the 43 who developed cancer. Their relationship with parents was bizarre--different from the others, and they scored low on the control scale of the MMPI. LeShan and Worthington noted that the significant loss of a love object was a common factor in the development of cancer. Bacon and Cutler found in breast cancer patients a marked inability to express emotions, namely, anger, aggression, and hostility. Kissen noted the inability to express hostility and other emotions as well as a poor emotional outlook among cancer patients.[7]

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[7]O. Carl and Stephanie Simonton, "The Role of Mind in Cancer Therapy" (Recorded by Cognetics, Saratoga, CA, 1975).

What is being said in the literature? The cancer patient bottles things up, does not react outwardly to stresses and experiences, and does not have sufficient emotional outlets for ventilating emotional feelings.[8]

There are over 200 articles in the medical literature dealing with different aspects of the relationship between the emotions and stress to malignancy, all of them concluding that there is a relationship. Eugene P. Pendergrass, former president of the American Cancer Society stated the following:

> I personally have observed cancer patients who have undergone successful treatment and were living and well for years. Then an emotional stress such as the death of a son in World War II, the infidelity of a daughter-in-law, or the burden of long unemployment seem to have been precipitating factors in the reactivation of their disease which resulted in death. . . . There is solid evidence that the course of disease in general is affected by emotional distress. . . . Thus, we as doctors may begin to emphasize treatment of the patient as a whole as well as the disease from which the patient is suffering. We may learn how to influence general body systems and through them modify the neoplasm which resides within the body.
>
> As we go forward . . . searching for new means of controlling growth both within the cell and through systematic influences it is my sincere hope that we can widen the quest to include the distinct possibility that within one's mind is a power capable of exerting forces which can either enhance or inhibit the progress of this disease.[9]

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[8]Jeanne Achterberg, O. Carl Simonton and Stephanie Matthews-Simonton (eds.), Stress, Psychological Factors, and Cancer (Fort Worth, TX: New Medicine Press, 1976), p. 4.

[9]O. Carl and Stephanie Simonton, "Belief Systems and Management of the Emotional Aspects of Malignancy," Journal of Transpersonal Psychology, VII, 1 (1975), 30.

Simonton and Simonton stated that from their review of the literature and from experience the biggest single predisposing factor to the development of cancer was the loss of a serious love object, occurring 6 to 18 months prior to the diagnosis. Obviously, not everyone who experiences a serious loss develops malignancy or some other disease, because this is only one factor. The loss whether real or imagined, must be significant, to the extent that it creates a feeling of helplessness and hopelessness. Thus, it is more than a loss, it is the culmination of the life-history pattern of the patient.[10]

## PERSONALITY FACTORS

When considering the personality attributes of cancer patients, it was noted that many reputed authorities claimed there is no cancer personality. The Simontons disagreed with this view. On the other hand, they support the position of Friedman and Rosenman in Type A Behavior and Your Heart that there is a life-history pattern in the development of heart diseases. The Simontons believe if we continue to look we will find predisposing psychological factors in the development of all disease.[11]

> Those predisposing factors most agreed upon as (negative) personality characteristics of the cancer patient are: (1) a great tendency to hold resentment

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[10]Ibid., p. 30. [11]Ibid.

> and a marked inability to forgive, (2) a tendency towards self-pity, (3) a poor ability to develop and maintain meaningful, long-term relationships, (4) a very poor self-image.[12]

One of the major underlying factors behind personality characteristics is a feeling of basic rejection--usually by one or both parents, and this develops into a life-history pattern. Carl Simonton stated the following: "All of us have a certain amount of this in our own personality. I probably have more than many. Of course, I developed cancer when I was 17, so I should have more than many."[13] He also believed it is possible to make changes in the cancer personality but the patient may be resistant to change. Friedman and Rosenman pointed out in their book that the heart patient resists the fact that he has this type of personality and the cancer patient resists even more strongly, since the heart disease personality is basically a much more socially acceptable personality than the cancer personality.[14]

## FACTORS IN PATIENT'S PROGRESS

What can be done? Can life history patterns be changed? It is difficult to change life patterns because these are areas people seldom consciously question. The Simontons cite the following factors that influence how

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[12]Ibid., pp. 30-31. [13]Ibid., p. 31. [14]Ibid.

patients present themselves and progress through treatment.

1. Belief system of the patient.

2. Belief system of the family and others who surround the patient and are meaningful to him.

3. Belief system of the physician.

The belief system of the patient has a significant role in the course his body takes during and after treatment. Most patients see cancer as synonymous with death, and as an alien force that there is almost no hope of controlling. Most patients have negative feelings about treatment--radiation therapy, chemotherapy, or surgery. The patient's belief about himself often involves a very poor self-image. It is mandatory to modify this image and these negative feelings early if the course of the disease is to be modified significantly. Most patients see themselves as victims of the disease, having no part in its development, and believe they can do nothing personally to help themselves get well.[15]

The belief system of the family is extremely important because we communicate what we believe to those around us. Much more time is spent with the family than with health-care personnel; hence educating family members and changing their beliefs about the disease are vitally important in influencing the patient.

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[15]Ibid., p. 32.

Most physicians are not aware that their own beliefs about the treatment and the disease can have an influence on the patient's ability to influence the outcome. The problem arises when the physician's belief system parallels that of the patient and the family--that the disease comes from without, is synonymous with death, that treatment is bad, and that the patient can do little or nothing to fight the disease. This belief is common among physicians. Simonton said:

> I know, because I have a large number of acquaintances who are cancer specialists, and I've heard them make statements like, "There is nothing that can be done." This, to me, indicates how they really feel about what a person can individually do to heal himself much more strongly than what they might intellectually tell me.[16]

## SPONTANEOUS REMISSION AND VISUALIZATION

Cases of spontaneous remission or unexpectedly good responses have been studied to determine if there were one or more common factors in each case. Simonton found in all these kinds of cases that they have visualized themselves as being well. He said it might be a spiritual process or God healing them, but it was important what they pictured and the way they saw things. Recovery correlates with seeing things positively. How the patient pictures things reveals a tremendous amount about how he will handle

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[16]Ibid., p. 32.

his disease and treatment. The patient is not aware of what he is revealing in these pictures and thus more is indicated that what the patient relates consciously. Simonton said, "If I had nothing but one tool to use in looking at my patient's attitude, it would be how regularly he is relaxing and what his imagery is."[17] Early in the treatment program the patient is shown a set of slides that depicts some of the best responses to the disease. So the patient can have a powerful image of what is possible and can see the potential of the body in getting rid of the disease with a minimal reaction to treatment.

## TYPE OF PRACTICE AND PATIENTS

Dr. Carl Simonton is in private practice with another radiation therapist in Fort Worth, Texas. The majority of their patients come through normal referral channels from other physicians (80-90 percent). Patients are treated with both medical treatment (radiation therapy, chemotherapy, or whatever is appropriate) and psychotherapy. Most patients come not knowing that they are going to receive psychotherapy with their regular radiation therapy. Over one half of these patients who come through normal medical channels will not participate in any form of psychotherapy. They will not participate in group therapy

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[17]Ibid., p. 33.

and will not use the relaxation and visualization techniques. Many will not talk about the psychological aspects of their disease--they might even go back to their physician and ask to be referred to another doctor.[18]

One of the types of patients they are beginning to receive from the local community are those who do not have active cancer currently. They may have been free from cancer for one to three years but are coming for help in dealing with what is a residual of cancer--fear of recurrence, reactivation, and the possibility of death. Every new ache and pain is suspect and they need concrete techniques to deal with these.[19]

The other type of patient is the referral from out of town and out of state. Some are accepted just for psychotherapy. They may be receiving medical treatment from a local physician in their own community, or there may be no appropriate medical treatment in their case. They believe there is a psychological component to their disease and they ask for help in participating more positively in their future.[20]

In one group of patients receiving this kind of treatment the average age was 44 and the average number of years of education was 17.5. They can be characterized as individuals with a "high tolerance for ambiguity" and as

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[18]Ibid. [19]Ibid. [20]Ibid.

"open-minded." They can try on new belief systems without throwing out all their old belief systems and without becoming terribly defensive. They can take something new into their lives even if it does not agree with things they base their lives on. They are able to explore problems and to look honestly and realistically at themselves without feeling personal failure. Some people feel they would be opening up a "can of worms" if they participated in this program. These people are willing to open up the can. They are nonconformist with high scores on the nonconformity scale of the MMPI.[21]

## TREATMENT CONCEPTS

The most difficult thing for patients to deal with is the idea of personal responsibility. This is contrasted with the concept that we have no participation, that disease is an outside agent acting in our body, and we have nothing to do with its getting there. To believe that one can mentally influence the body's immune mechanisms means recognition that mind, emotions, and body act as a unit and cannot be separated. Patients have a better grasp of the future when they understand there are psychological as well as physical reasons underlying their disease. A distinction needs to be made between responsibility and blame.

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[21]Simonton and Simonton, "The Role of Mind . . ."

It is a common conception that if we accept responsibility we are to blame, should feel guilty, or have done something wrong. At the Fort Worth Clinic it is stressed that we need not feel guilty; we simply have emotional needs that are not being met.[22]

At the orientation session, family members and close friends are invited to attend. It is explained how the mind interacts with the body and how attitudes play major roles. The relaxation and visualization techniques are explained. Cancer patients are taught how to visualize the disease, the treatment, and their own immune mechanisms (white blood cells). In the group sessions, which are held twice a week, they talk primarily about the relaxation and imagery process. They talk about why the patients are not using it. Often the things that are preventing them from quieting themselves, listening to themselves, and visualizing, are the things that are causing life to lose meaning. They tend to uncover the things that are preventing them from getting well.[23]

## SECONDARY GAINS

Efforts are made to get patients to see the

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[22]Simonton and Simonton, "Belief Systems . . .," p. 37.

[23]Ibid.

secondary gains of their illness by helping them to see how different their lives are now than before they developed the disease. The example was cited of a woman with breast cancer. Just as she was developing the disease her children were growing up, graduating from school, and beginning to enter their own lives. Her husband was preoccupied with his job. She suddenly felt unneeded. After cancer developed the husband gave her much more attention. She was helped to see that if having disease was the only way she could get attention, then it must continue for her to assure secondary gain, her husband's affection. The goal was not to cut off his affection but to develop healthier ways of getting the support she needed emotionally.[24]

## DIFFICULTIES AS THERAPIST

1. There are no blueprints or manuals.

2. More humanness is required rather than professional knowledge.

3. There must be willingness to accept responsibility for personal health. What is the emotional participation of the therapist? Personal exposure is required.

4. There must be willingness to look at death--intellectually, emotionally, and spiritually.[25]

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[24]Ibid., pp. 37-38.

[25]Simonton and Simonton, "The Role of Mind . . ."

## RELAXATION AND MENTAL IMAGERY

Pelletier says, "The visualization technique itself is so simple that it at first seems improbable that such dramatic results could come from such a deceptively simple procedure."[26] In the Simonton program the patients are first taught a simplified form of relaxation with a focus on breathing. When the patient achieves a state of physiological relaxation, he visualizes a pleasant, natural scene, such as a brook in the meadow or whatever occurs to him. He then visualizes the illness as it appears, such as hamburger or cauliflower. Then the form of treatment is visualized. If the treatment is radiation therapy, bullets of energy are visualized as hitting the cells of the tumor. An army of white blood cells is visualized as transporting dead cancer cells through the blood, liver, kidneys, and then out of the system. The cancer is visualized as shrinking and responding to treatment. If the treatment is chemotherapy, the cancer cells are visualized as poisoned rather than nourished and the normal cells which can resist minor damage are visualized as thriving.[27]

The procedure of relaxation and mental imaging is practiced three times a day at the Clinic at Fort Worth,

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[26]Pelletier, p. 260.

[27]Ibid., pp. 260-261.

Texas, and by patients who obtain the cassette recorded by the Simontons. The sessions are recommended before breakfast, after lunch, and at night before going to bed. The following is a paraphrase of the directions for the relaxation and mental imaging procedure.[28]

With eyes closed take a comfortable position, sitting, not lying down, so you won't go to sleep.

Take deep breaths. Become aware of tense muscles.

Open mouth very wide--let the jaws fall--this is a good way to release tension.

Become aware of muscles in your neck. Mentally command them to begin to relax. Much tension is held in this area.

Be aware of those muscles across the shoulders. Allow these areas to be more relaxed.

Become aware of your chest, lungs--concentrate on the contents of the chest cavity. Give the command to relax, allowing tension to flow out thus giving the body more energy which it can use in a more productive way.

Become aware of tension in the abdomen, especially abdominal muscles, and all contents of the abdominal cavity. Picture them; see them relaxing. Hold in mind a picture of a bundle of very limp rubber bands; gradually feel the tension leave.

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[28]Simonton and Simonton, "The Role of Mind . . ."

Allow the pelvis to become more relaxed, then the legs, feet, arms, and hands.

Picture yourself in a nice pleasant scene from nature, like lying on a creek bank in tall grass under a shady tree. Picture this scene near a stream and hear the rippling water. Focus on this scene; this helps to relax and at the same time helps one to become more mentally alert.

Pause 90 seconds while picturing that quiet scene from nature.

The purpose of reflection and mental imagery is to improve health.

At this point, picture your cancer in a way that makes sense to you. Realize many of our preconceived ideas about cancer are false. We normally think of the cancer cell as being a very strong cell, a powerful cell. This is not true. The cancer cell is a very weak confused cell. It only grows when our bodies are weakened. Normal healthy cells reject cancer cells. A healthy body destroys cancer cells thousands of times during a normal life. When bodies become weakened cancer cells can grow into a tumor.

Picture the cancer cell in some vital way, in a clear manner such as raw hamburger or liver. See the design of the human body with cancerous areas in black. Realize the cancer cell is a weak cell. It is important for normal cells to return to a full healthy state and they

will eliminate cancer cells.

Keep thinking of the cancer cell as a weak and confused cell.

Picture your treatment. If radiation therapy, picture that beam of energy hitting normal cells and cancer cells. The normal cells are strong and can repair damage. The cancer cells are weak and cannot repair damage. This is the basic principle of cancer radiation therapy. Healthy cells fend off rays; sick cells are killed by them. See this happen to help the therapy or curing process along.

If the treatment is chemotherapy, picture the drug coming into the blood stream by pills or injection. The cancer cells in the blood stream are poisoned by the drug. The drug is not able to damage healthy cells. If they are slightly damaged, they have the wonderful gift of self-repair or healing. Normal cells are strong, and sick or cancer cells are weak. It takes very little to kill them and flush them out of the body. See this happening and appreciate the different forms of treatment developed by the medical profession to help our bodies return to their healthy state.

Now the most important step is to imagine the white blood cells, a vast army of millions upon millions within you to eliminate abnormal cells and conditions. Picture the white blood cells as very strong. They are very aggressive. They recognize the abnormal cells, the cancer cells, and

destroy them. See these white cells as almost without number. The cancer cells cannot resist them. A person only develops cancer because the white blood cells stop attacking. Thus, encourage the activity of the white blood cells in your mind and imagination; cheer them on. See the cancer cells shrinking, dying, and being sloughed off through the liver and kidneys. We expect this to happen. Picture yourself feeling a bit better, even if extremely difficult to do. In time it will get easier. Look ahead. Have hope. Feel yourself becoming more in tune with life, having a better appetite, and being better able to relate to persons in your family and community. Become aware of goals and attitudes because they are important to healthy persons. See these very clearly. These are our reasons for living. Set the goals and hold them strongly. See all this in your mind's eye and imagination.

If you are having some problem with pain in the shoulder, back, leg muscle, or abdomen, for example, and are tempted to think it is the disease of cancer spreading somewhere else, do the following instead: focus your mind on the pain and see the body's wonderful responses flowing into that area to make it healthy. Give the body the command to repair whatever is wrong. Give the command and picture it happening. See the body returning to normal. Feel yourself getting better.

Anytime during the day the thought of new sickness or setback comes, give the command to send the resources of the body to that point to heal. Become aware of the tension that pain creates in us. Say, "I have the ability to repair myself and relax."

You are developing a mental exercise for better health. With any new skill practice is very important. Practice three times daily. Stay mentally awake and alert throughout the exercises. Do this regularly until it becomes a part of you. Participate in your own health more actively.

At the conclusion of the exercise, open your eyes and go about your daily activities.

## SUMMARY

This chapter described an innovative approach to the care of cancer victims. The use of visualization, along with psychotherapy and traditional methods, by the Simontons in Fort Worth, Texas, is special in that it is the first time this type of approach has been attempted directly with cancer patients along with attempts to assess results scientifically as compared with other methods.

# Chapter 4

## PASTORAL CARE AND THE CANCER PATIENT

It may seem that healing should be left to doctors and nurses, but the crisis of illness is more than the battle against bacteria. "Illness is always a spiritual crisis, of patience in adversity, of hope against despair, and of the will to live or die."[1] Furthermore, emotions and attitudes are profound factors which can determine whether the patient gets well, fails rapidly, or becomes a chronic invalid. A half century of literature in pastoral psychology underscores the therapeutic potential of pastoral care at the bedside, as well as relationships between faith, attitude, belief, life style, and disease.

## THE PSYCHODYNAMICS OF ILLNESS

> One is never ready for illness; it is always inconvenient, often unacceptable, and intolerable either to bear in the anguish of its distress or to accommodate in the ongoing course of life. It is a blow that shatters the security of life.[2]

Illness can be a crisis producing situation. Switzer cited two factors involved in illness. (1) The concept of the body image is related to the concept of the whole self.

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[1]Paul E. Johnson, Psychology of Pastoral Care (Nashville: Abingdon Press, 1953), p. 194.

[2]Ibid., p. 193.

The infant learns to distinguish between what is outside his skin and what is inside, to delineate his own body from the rest of the world. The physical self is incorporated into the image of the total self. During illness, the perception of threat to the physical self is experienced as anxiety. This perception is not always proportionate to the seriousness of the disorder. (2) In facing this anxiety, one's personal world begins to break down. This means a breakdown of meaningful relationships. In the case of the hospitalized patient, he is removed from familiar surroundings and placed in a new and strange situation. There is a threat to personal identity which has been based on one's relationship with the community. Illness in general, and cancer in particular, are perceived as threats to the self. There is some degree of loss of those objects and persons that have become a part of personal identity, as well as reduced resources with which to cope with one's feelings. The pastor who understands this can provide an opportunity for the patient to express his feelings, to objectify them, thus reducing the pressure of them. The pastor also gives an increased sense of personal support and the support of the community of faith.[3]

Johnson related his own experience as a hospital

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[3]David K. Switzer, The Minister as Crisis Counselor (Nashville: Abingdon Press, 1974), pp. 47-49.

patient. He described the disturbing effect of pain, how dominating it was, and how other interests occupied the periphery of consciousness. His entire personality was drawn into its orbit with its hypnotic power. He became egocentric and all energy was involved in coping. He became introverted, not by choice, but was powerless to do anything but suffer intensely. The pain created social distance. He felt rejected, cut off from the comfortable feeling of being in a care-free society. Like Job or the writer of Psalm 22, he was forsaken. The mental anguish was more acute than the physical pain. He had lost the values of health, freedom, and the power to do things. Would he live or die? Would he be disabled? Would he be able to work or would his family be deprived of economic necessities?[4]

Johnson described how he regressed to a state of dependence and felt weak and helpless as a baby. He recalled half-consciously the struggle to outgrow the dependency of childhood. Feelings of inferiority were recalled from an earlier world of stronger people. He tried to urinate while flat on his back, and it was like slipping back into infancy in a single day. He acted and felt like a baby while being assaulted by giants in white who told him what to do and when to do it. His manhood was

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[4]Johnson, pp. 199-203.

threatened in a very real sense. Would he become addicted to dependency with the preference to be an invalid while others waited on him?

After a few days, Johnson sensed a feeling of protest and rebellion. Why was he suffering? How can a good God permit such suffering? Then the disturbing thought occurred that the suffering was a consequence of mistakes and sins. What had he done, or left undone? Hostility against fate now turned inward and became a sense of guilt. Emotional attitudes are often the decisive factor in recovery, and if they can be changed, we are accountable. This is unwelcome since, if the condition is beyond control, we can feel blameless. Johnson concluded that the responsible role in creating our own health is not punishment of ourselves for past regrets but attention to present choices and unused resources for health.

> This is not to oversimplify the causes of illness or the conditions of health, as some religious groups may do in blindly trusting a supernatural power to perform miracles for irresponsible persons who do nothing but come to a shrine or platform to be externally changed. True healing is always spiritual, but it is not mechanical like lightning that strikes from above without warning. It is rather a new life that starts to grow from the inmost center of personality.[5]

Faber also suggested regression occurs in the emotional life of patients. Childish emotional and

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[5]Ibid., pp. 202-203.

behavioral patterns reemerge. This means falling back to earlier emotional patterns which make fear and uncertainty easier to cope with. Sometimes there is abject submissiveness. Sometimes there are stubborn attempts to maintain links with their own world through trying to work and worrying about the work. The emotional life is pitched at a more childish level. Doctors and nurses provide necessary reassurance and security. Members of the family are experienced as visitors from a distant world. The patient will need to work through aggressive feelings without necessarily being aware of what is happening. Complaints about food, nurses, and other things, or excessive glowing should cause one to suspect difficulty in adjustment. When aggression cannot be expressed it is turned inward as self-reproach and guilt feelings. It is well for the pastor to be aware of the existence of childish emotions in patients and to listen carefully for feelings of guilt.[6]

Faber listed the following psychological characteristics common in those who are ill:

1. They often lose their usual inhibitions. There is an atmosphere of intimacy among patients in which they relate intimate details of their personal lives. Remarks

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[6]Heije Faber, Pastoral Care in the Modern Hospital (Philadelphia: Westminster Press, 1971), pp. 19-21.

about food, nursing staff, and fellow patients are treated with more abandon than normal.

2. They are childish and demanding in unrealistic ways. They expect many people to visit and always be friendly and cheerful. They make unreasonable requests from nurses for trivial services and keep them engaged in unduly long conversations.

3. There is an increase in tenderness. This characteristic is the mark of a child and typical of a sick man. He is easily moved to tears and may show extreme gratitude to his wife or the nurse for what they do for him.

4. The sick person is usually not very brave. Frequently there is an infantile lack of preparedness to accept realities. Men who are normally decisive may react childishly regarding taking medicine and carrying out the doctor's orders.[7]

There are many factors in the modern hospital that tend to make the patient weak and regress to infantile behavior patterns. He is removed from familiar surroundings. He becomes the recipient of treatment from complicated and painful equipment. He develops faith in the magical powers of modern medicine or depressing fear it all will do no good.

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[7]Ibid., pp. 24-27.

> We ought also to recognize that the very impressiveness of the modern technical equipment at the disposal of today's medical staff suggests to some patients that their condition must be serious, a notion they sometimes find hard to resist.[8]

## PASTORAL CARE

The pastoral visit is more than a social call or a break in sickroom monotony; it is a healing ministry. The instruments which have been used for centuries are prayer, scriptures, sacraments, and touching. Pastoral care also incorporates friendly personal interest, empathy (i.e., understanding), compassion, and more formal counseling when the person is ready. The pastor will proceed thoughtfully according to the ability of the person to accept care. Faber stated the following concerning the need of the pastor to start where the patient is:

> We can only help the sick when we are ready to accept them in the reality of their situation, without any attempt, conscious or unconscious, to force or reproach them. It is surprising how often the latter happens.[9]

The pastor approaches the sick person with an open mind and is available to react to those things the patient wants to share. Reactions must be geared to the patient and not to knowledge gained from the doctor or the patient's chart.[10]

The pastor seeks to "personalize" the situation.

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[8]Ibid., p. 63. [9]Ibid., p. 33. [10]Ibid., p. 97.

He encourages the patient to be human and provides an opportunity for him to talk about the illness and accompanying frustrations. Although the pastor is aware of the psychological implications of regression, he appeals to the adult mature side of the patient. He further personalizes the situation by representing the religious fellowship of the community of faith and by mediating the love of a God who cares.[11]

Pastoral care is characterized as responsible caring. The patient has the need for warmth, security, and rest but he also has the right to think for himself. To care means not only seeing the patient as an object of care but also as a subject given the opportunity to share responsibly. "Sometimes he [the pastor] joins in regarding the patients as the objects of (pastoral) care."[12] The genuine pastor uses a different approach. He sees people as subjects and tries to enter into a relationship with them if that is their desire. He is there, he listens, and where it is real for them in their situation, journeys with them in the light of the gospel.

It has frequently been the role of the pastor to comfort the sick and prepare them for the end, especially in the case of the cancer victim who was considered terminal. There are other aims present today in pastoral

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[11]Ibid., p. 33. [12]Ibid., p. 17.

care, such as promoting a sense of belonging in the community, assisting in coping with sickness in faith, changing attitudes toward suffering and death, and encouraging cancer patients to live at a deeper level.

"Make Today Count" is an organization that concentrates on living and is devoted to improving the quality of life for the terminally ill and their families. The organization was founded by Orville E. Kelly who has lymphocytic lymphoma, a cancer of the lymph glands, and whose prognosis in 1973 was from six months to three years to live.[13] At a doctor/clergy seminar in San Diego, David J. Peters, M.D., a cancer patient who has had ten surgical operations, and who serves as the Regional West Coast Consultant for "Make Today Count," talked about pastoral relations with cancer patients. He prefers an emphasis on living during whatever time remains rather than emphasis on death and dying, in spite of the popularity of the latter subjects in present-day academia. Peters stated he was asked by a clergyman during one of his hospital confinements whether he was ready to die and he felt inclined to respond with the same inquiry to the clergyman. Although he does not particularly care for the term "will to live" he believes this concept is a more positive emphasis than

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[13]Judith Ramsey, "Make Today Count," Reader's Digest, CXII, 670 (February 1978), 27-34.

preparation for death. Peters further said although no studies have been done to determine the effect on longevity of cancer patients' involvement in "Make Today Count," he speculated that there would be a positive correlation between their outlook and longevity.[14]

Pastoral care of the cancer patient requires a sensitivity to expression of guilt. Guilt has a paralyzing power which contributes to breakdown in health. Psychology can do much to bring to consciousness those factors that produced the guilty feeling but it has nothing to say about forgiveness and redemption. Guilt creates intolerable feelings of loneliness and helplessness in the patient.[15] His suffering is often interpreted as divine punishment for his sins. Hence his theology increases the unhealthy state of mind. The process theology position with regard to suffering, described in Chapter 5, can be used to avoid this negative interpretation, and to support the view that God is on the patient's side, that there is a divine healing power with which he can cooperate. The patient is part of a total system which can function in a healing way.

Weatherhead pointed out it is frequently forgotten

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[14]David J. Peters, "Both Ends of the Stethoscope (Address at Doctor/Clergy Seminar, San Diego, CA, March 15, 1978).

[15]Leslie D. Weatherhead, Psychology, Religion and Healing (New York: Abingdon Press, 1952), p. 342.

that all healing is the activity of God, and the function of man in the healing process is to cooperate with God. The important thing is to discover the most relevant way of cooperating with God.

> Even prayer is not necessarily a more religious procedure than an operation. . . . Prayer is obviously not the best way of making a man walk whose leg has been shot off by a shell. Designing and perfecting an artificial limb probably is. And to do this latter in a scientific way, for the sake of helping a sufferer, can be as "religious" an act as prayer, and much more relevant.[16]

The pastor's role in caring for the cancer patient is therefore an inward voyage. He enters into the inner life of the cancer victim, accepts him where he is, and seeks to facilitate genuine understanding and communication. He allows honest expression of anger, hostility, and feelings of guilt. In all of this God is using the pastor as an instrument to facilitate the healing process.

Pastoral care is not a routine passage through familiar ruts, at least it ought not to be. The pastor wrestles with the problem of creating a relationship with patients which requires continuous self-examination. He must be creative and genuine. He must appreciate the pangs of doubt and unbelief which the patient faces. Belief is not a possession to be handed out routinely. The pastor can only hear doubt and disbelief in the patient if he is

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[16]Ibid., 437.

tuned to hear doubt and disbelief in himself.[17]

Switzer described the power or effect of the pastor as a symbol. Apart from his own being as a person he is perceived by others as a symbol of the reality that underlies the meaningfulness of Christian faith.

> His very physical presence has the power to stimulate those internal images which, through early learning in a highly emotionally charged relationship of dependence, have become a part of an individual's intrapersonal dynamics. These primitive urges are a part of that individual's internal resources and are strong unconscious forces affecting every aspect of life.[18]

It must be recognized that in a number of people these images have negative forces attached to them. Faber suggested the symbolism of the pastor is often linked with dying. For the fearful patient who is uncertain about the outcome of the illness the symbol of the pastor can confirm his suspicions that the end is near. On the other hand, the pastor stands for a positive, meaningful perspective on death. He represents the love of God which is stronger than death. The symbolic value of the pastor, however, can be effective only if he lets himself be experienced as such. He must listen and share; then the gospel can become a liberating power. "Experience shows that the gospel message has no effect when it is 'tossed

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[17]Faber, pp. 87-88.

[18]Switzer, p. 23.

to' the sick from a distance."[19]

## SUMMARY

This chapter described the psychodynamics of illness. Illness is defined as a crisis resulting in changes in mental outlook and behavioral patterns. The chapter was concluded with a description of pastoral care and the concept of the pastor as a symbol.

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[19]Faber, p. 65.

# Chapter 5

## THE WHITEHEADIAN-PROCESS THEOLOGY PERSPECTIVE

The nontraditional approach to cancer used by the Simontons points out that the state of the mind is very important in causing, preventing, and treating cancer. Those involved in pastoral care have also long noted that the state of the mind was central in causing and overcoming illness in general. Is there a philosophical-theological perspective that would give support to these empirical findings and which, if adopted, could be helpful as a belief system, both for the therapists and the patients? It is proposed that the Whiteheadian-process theology perspective does provide a belief system that is helpful in considering the influence of the mind on the body.

The Simontons pointed out the numerous negative beliefs of the cancer patient, such as seeing cancer as synonymous with death, and as something from without with almost no hope of controlling the disease. Most patients have negative feelings about treatment and very poor self-images. The one negative belief the pastoral counselor should be especially equipped to deal with is the negative belief about God, that God is punishing the cancer victim for his sins. Illness is frequently equated with divine punishment for sins. The process theology position can

be used to avoid this negative interpretation, and to support the view that God is on the patient's side, that there is a divine healing power with which he can cooperate.

## PHILOSOPHICAL THEOLOGICAL BACKGROUND

Griffin pointed out there is a pervasive attitude among seminarians and even many seminary professors that philosophical theology is not one of the real necessities in preparing for the pastoral ministry. In addition to the traditional courses in the curriculum, courses such as psychology, counseling, social ethics, and sociology have been considered absolute necessities, while the study of philosophical theology seems to "many a luxury at best, and at worst an irrelevant requirement or elective."[1] Without engaging in a fruitless discussion of which of the disciplines are more necessary, he suggested that "reflection upon the issues of philosophical theology is one of the essential elements in preparing for the pastoral ministry."[2] Whitehead emphasized the necessity for more than a common-sense or emotional approach to religion when he said:

> Religion requires a metaphysical backing; for its authority is endangered by the intensity of the emotions

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[1]David R. Griffin, "Philosophical Theology and the Pastoral Ministry," Encounter, XXXIII (Summer 1972), 230.

[2]Ibid.

> which it generates. Such emotions are evidence of some vivid experience; but they are a poor guarantee for its correct interpretation.[3]

Whitehead defined philosophy as "the endeavor to frame a coherent, logical, necessary system of general ideas in terms of which every element of our experience can be interpreted."[4] He further defined philosophy as follows:

> Philosophy is an attitude of mind towards doctrines ignorantly entertained. By the phrase "ignorantly entertained" I mean that the full meaning of the doctrine in respect to the infinitude of circumstances to which it is relevant, it not understood.[5]

This attitude seeks to enlarge the understanding of the scope of application of all ideas which enter into thought. The meaning of every word, phrase, and verbal expression is sought. It "refuses to be satisfied by the conventional presupposition that every sensible person knows the answer."[6]

It is not within the scope of this study to define the broad metaphysical backing of religion. The study has presented primarily a description of empirical evidence in certain areas of cancer patient care. The overall aim of the study is to explore means of increasing effectiveness

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[3]Alfred N. Whitehead, Religion in the Making (New York: New American Library, 1960), p. 81.

[4]Alfred N. Whitehead, Process and Reality (New York: Free Press, 1969), p. 5.

[5]Alfred N. Whitehead, Modes of Thought (New York: Free Press, 1968), p. 172.

[6]Ibid.

in pastoral care and particularly pastoral care of cancer patients. Information concerning options available to cancer victims and possible alternatives to traditional treatment should increase the effectiveness of pastoral care. In addition to empirical knowledge, the rational side is equally important for an effective ministry. The mind-body problem and the problem of suffering are, therefore, considered from a Whiteheadian-process theology perspective. These two areas seem to be particularly relevant to a study of approaches to care of cancer victims.

## THE MIND-BODY PROBLEM

### The Relationship Between Mind and Body

The problem of the relationship between the mind and body was recognized many years ago.

> In 380 B.C., Plato, in the Republic, recognised the influence of the mind and the emotions upon physical health. Socrates related to Plato the story of a charm which the former had obtained from a physician, who, in giving it to him, had advised him thus: "The cure of a part should not be attempted without the treatment of the whole, and also that no attempt should be made to cure the body without the soul, and therefore if the head and body are to be well, you must begin by curing the mind: that is the first thing." And he who taught me the cure of the charm added a special direction: "Let no one persuade you to cure the head until he has given you his soul to be cured. For this," he added, "is the great error of our day in the treatment of the human body that physicians separate the soul from the body."[7]

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[7]Leslie D. Weatherhead, Psychology, Religion and Healing (New York: Abingdon Press, 1952), pp. 105-106.

Descartes' philosophy was based on the concept of mind and body as individual substances. "Now in some sense no one doubts but that there are bodies and minds. The only point at issue is the status of such bodies and minds in the scheme of things."[8] There is a unity in the relationship between mind and body because the human being is one fact. The functioning of the body has a much wider influence than mere production of sense experience. We enjoy life because of the healthy functioning of internal organs. We enjoy our emotional state because these organs are not providing sensations associated with themselves. For example, we enjoy our vision because there is no eyestrain and our general state of life because we have no stomach ache. Emotional states are modified by derivation from the body. A fundamental fact of philosophy is that complex mental experience is either derived from or modified by bodily functioning.[9]

Immediate experience is also derived from a source other than sense experience, and that is the state of the mind directly preceding the immediate conscious experience. The present state of mind is a continuation of a split second ago. Ideas and emotions of the previous state are continued and "we claim absolute identity with our previous

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[8]Whitehead, Religion in the Making, p. 102.

[9]Whitehead, Modes of Thought, pp. 159-160.

state."[10] In a sense, however, we do not continue the exact state of experience. Bodily functionings have provided new elements, and these are fused with the state of mind of a quarter of a second ago. The experience of the present is thus derived from the body and the antecedent experiential functionings. We identify with each of these sources: the body and the antecedent experience. But there is only one ego to claim this experience.

> I submit that we have here the fundamental basic persuasion on which we found the whole of our existence. While we exist, body and soul are inescapable elements of our being, each with the full reality of our own immediate self.[11]

For Whitehead, physical and mental are not "two different types of actual entities but two aspects of every occasion of experience."[12] The term "mental" is expanded beyond normal usage to refer to novelty appearing in an occasion. Novelty is negligible in low-grade occasions since they receive data from the past, repeat it, and pass it on practically unchanged. We can therefore refer to the solidity and permanence of rocks as well as the everlasting hills because they seem to endure forever.[13] Whitehead said, "Consciousness presupposes experience, and

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[10]Ibid., p. 160. [11]Ibid., p. 161.

[12]David Griffin, "The Possibility of Subjective Immortality in Whitehead's Philosophy," Modern Schoolman, LIII (November 1975), 47.

[13]Ibid., pp. 47-48.

not experience consciousness."[14] Thus, "it is possible to attribute experience to low-grade actual entities without supposing they have conscious experience."[15] Whitehead's doctrine that all entities have "mentality" or "conceptual prehension" is often misunderstood. It does not mean they all have intellect or even consciousness. The first level at which significant novelty occurs is the living cell.[16]

Hartshorne posed the question of whether there might be a psychology of single cells. They react to stimuli and organize their internal activities remarkably well, especially single-celled animals and plants. This may be true of all cells. Even if trees and plants do not have feelings or sensation, the individual cells may feel and enjoy their activities. "In that case, mind in some form may pervade the entire kingdom of living things. I take this view, and so do some other philosophers and scientists."[17] A distinction must be made between conscious purpose formulated conceptually and deliberately aiming at future results and primitive, short-run, naive

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[14]Whitehead, Process and Reality, p. 67.

[15]David Griffin, "Whitehead's Philosophy and Some General Notions of Physics and Biology," in Mind in Nature (Washington: University Press of America, 1977), p. 126.

[16]Ibid., p. 129.

[17]Charles Hartshorne, "Physics and Psychics: The Place of Mind in Nature," in Mind in Nature, p. 91.

intention.

In the case of pain we have a feeling of pain if cells are damaged. If cells have their own feelings they do not enjoy being damaged. Our suffering is thus participating in their suffering. Cells are friends which we always have with us.

> The mind-body relation, I suggest, as Plato hinted long ago, is a relation of sympathy; it is the most instinctive of all forms of sympathy, the form we are born with and do not have to learn. I seriously believe, and not alone I, that this is the key to the influence of body upon mind. There is mind on both sides of the relation, but mind on very different levels.[18]

This gap, Hartshorne suggested, between the mentality of cells of the body and mind is crossed by a kind of sympathy. When our cells are enjoying themselves and we are in good health we have a sense of well-being. In this way the bodily cells influence our feelings. This relationship likewise results in our feelings influencing bodily cells by "sympathy in the reverse direction."[19] We share in the subhuman emotional life of cells and they in their subhuman manner share in our emotional life. According to the psychicalist view, physical nature is mind in other than human forms.

> The greatest geneticist I have known (Sewall Wright) believes with me that there is nothing in all nature except mind on various levels. The greatest two philosophers of recent times, on my criteria, also believed this. So have many other fine intellects. I am proud

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[18]Ibid., p. 92. [19]Ibid., p. 93.

> to be in their company. We are not a majority, but an elite minority.[20]

Psychicalism is not anthropomorphism and does not attribute human traits to apes or to atoms. Apes and atoms do not remember, perceive, or know as human beings. But atoms do take the immediate past into account or there would be no causal account of their behavior. Thus the psychicalist holds that they either remember or perceive or both.

Bagby summarized Whitehead's solution to the mind-body problem in the following dramatic and somewhat simplistic manner:

> Whitehead was confronted by these two problems: the discontinuities in the material universe, and the fundamental split between mind and matter. He solved both problems at a single stroke, by making a radical original assumption which is alone sufficient to justify his genius. He assumed that all physical events shared the fundamental characteristics of mental events, that the universe, in other words, was entirely composed of minds.[21]

## The Mind-Body and Cancer

As individuals, the cells of the body prehend their previous selves, other cells, and the mind. This is not conscious experience, but their relationship is one of causality between mind and body. The relationship of

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[20]Ibid., p. 94.

[21]Philip H. Bagby, "Whitehead: A New Appraisal," in Beyond the Five Senses (Philadelphia: Lippincott, 1957), p. 287.

sympathy described by Hartshorne permits the conclusion that cancerous cells are responding on some level to the functioning of the mind. The psychological factors found by research studies to correlate with cancer, such as loss of a love object or person, inability to express anger, self-hatred, and sense of hopelessness provoke a response of sympathy in the cells of the body. In some sense, these cells are unhappy in that they must develop in this manner. These psychological factors, along with carcinogenic agents introduced into the body through avenues such as air pollution, food pollution, and cigarette smoking are causative elements in the formation of cancer cells. No one actual entity is the direct cause because every happening in the community of actualities in the world is a factor in every other happening. In considering causation, Whitehead asked how one event can be the cause of another and he said:

> No event can be wholly and solely the cause of another event. The whole antecedent world conspires to produce a new occasion. But some one occasion in an important way conditions the formation of a successor.[22]

Whitehead is speaking of the multiplicity of efficient causes. Griffin says even all of these do not totally determine. "No organism is totally determined by the efficient causes upon it, since every actual occasion

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[22]Whitehead, Modes of Thought, p. 164.

has at least some iota of mentality or self-determination."[23]

The development of the cancer cell is thus not the result of any single causative factor but a response to the functioning of the entire human organism. Process philosophy supports the findings of research studies which found correlations between certain psychological factors and cancer development.

## THE PROBLEM OF SUFFERING

The problem of suffering is an issue which must be faced in the pastoral ministry and the theological position of the pastor is related to effectiveness in dealing with this problem. The doctrine of divine causation adopted will largely determine the manner in which suffering is considered. Human nature is such that it is common, when one is the victim of a life-threatening disease, to ask why. If God is conceived as Controlling Power, then it is logical to ask why God causes or at least permits the disease to occur. As Controlling Power, God is responsible for every detail and therefore for the development of such diseases as cancer in human beings. Suffering must be considered as being willed by God. God's goodness and wisdom is

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[23]Griffin, "Whitehead's Philosophy . . .," p. 132.

somehow expressed through human suffering.[24]

This doctrine ultimately leads to a denial of the reality of evil if "evil" is defined as anything without which the world would be better off or anything which occurs which takes the place of something that could be better. The goodness of God is questioned if we argue that all events are willed by God and yet that certain events should have been otherwise. In fact, this reasoning would lead to a rejection of the goodness of God. This argument would mean that the disease of cancer must finally be accepted as good because it is engineered by God. A variation of the doctrine of total determination is that of "occasional intervention." This means that God can step in at certain times and alter the course of events. For example, God could effect a cure of cancer in certain people while choosing not to take this course of action in other people. The implications are essentially the same. "If God is perfectly good, and has the power to prevent these apparent evils, and yet does not, it must mean that they are finally not evils, from the ultimate point of view."[25]

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[24]John B. Cobb, Jr. and David R. Griffin, Process Theology (Philadelphia: Westminster Press, 1976), p. 69; Griffin, "Philosophical Theology . . .," p. 232.

[25]Griffin, "Philosophical Theology . . .," pp. 232-233.

Process theology holds that divine causality is persuasive and not compulsive. God is not the only efficient cause of any event but one of many influences. Each actuality has some power for self-determination and this means the power to choose how to respond to the various efficient causes, including God. The persuasive influence of God means there are no events in which God's causality is not a real influence. God presents to each creature every moment an impulse toward the ideal possibility that would be the best possible at that time and in that actual situation. Since there are other causes affecting the actuality, and since the actuality has its own power, God does not completely determine the response. Each actuality has power that may be quite limited on the lower end of the hierarchy of beings, to accept or reject the ideal possibility offered or urged by God.[26]

God's relation to our minds is like that of our minds to our cells. Influence is through sympathy; it is one of many causes; it can therefore be an influence but not a total cause; how effective God is in us is partly up to us.

The ideal possibility presented by God is not absolute but conditioned by the particular situation that is the result of all decisions leading up to that moment.

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[26]Ibid., p. 232.

Since some decisions in the past were less than ideal the new possibility is relative but the best possible one at that point. Additionally, in the process view, a person's beliefs and attitudes play an important role in the way God can causally affect him.

> The person who does not believe in God at all, nor in the reality and effectiveness of ideal possibilities, will tend not to be receptive to the divine influence on him, even though it will be there.[27]

But why is there so much suffering? Two kinds of experience which are equally evil are triviality and discord. The distinction between these two evils is that discord, which is mental or physical suffering, is evil in itself whenever it occurs. Triviality is only evil in some cases. A trivial enjoyment is not evil unless it is more trivial and less intense than it could have been under the circumstances.[28]

Discord and unnecessary triviality are two forms of nonmoral evil. Discord, or physical and mental suffering, is commonly considered to be the major form of nonmoral evil, while triviality is ignored. This view suggests God's primary concern to be the elimination of all discord. If this were the case, the solution for God would have been not to stimulate the chaos into increasingly

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[27]Ibid., p. 242.

[28]Cobb and Griffin, p. 70.

complex forms of order, and discord would have been held down to an absolute minimum. This is a negative approach and if God is loving and moral the divine aim is to overcome unnecessary triviality while avoiding as much discord as possible. The divine aim is for perfection of experience that means the maximum harmonious intensity possible for a creature. The possibilities for disharmony are greater when there is more variety and intensity. But this is a necessary risk if there is to be perfection of experience.[29]

Another point in explaining the possibility of so much evil, including suffering, is the correlation among the following dimensions of experience: (1) the capacity for intrinsic good, (2) the capacity for intrinsic evil, (3) the capacity for instrumental good, (4) the capacity for instrumental evil, and (5) the power for self-determination. There is a positive correlation between these, which means that if any one of these dimensions increases the others also increase proportionately. This correlation is necessary and not dependent on choice, not even divine choice. Therefore, when God brought order out of chaos, the process conformed with these correlations.[30]

The positive correlation between the capacity for intrinsic good and intrinsic evil means that the increased capacity for enjoyment is accompanied by the increased

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[29]Ibid., pp. 70-71. [30]Ibid., p. 71.

capacity for suffering. The correlation between intrinsic good and instrumental good means that as more complex individuals develop in the evolutionary process there is increased capacity for enjoyment and greater values to contribute to others. An example of capacity of instrumental good correlating with capacity for instrumental evil is the bodily cells as a source of enjoyment of food, drink, exercise, and sex, while at the same time being the source of some of our greatest sufferings when deprived of their needs. The capacity for self-determination correlates with the other four dimensions. The more complex creatures have greater capacity for more intrinsic value as well as an increase in the number of novel real possibilities for actualization. At the same time an increase in self-determination means more freedom to reject divine aims. Increasing the freedom of creatures was risky business for God but it was necessary if there was to be greatness. This is the doctrine of essential limitation.[31]

God is therefore partly responsible for the evil of discord. Had God not stimulated the realm of finitude out of chaos into an ordered existence with the development of more complex forms of actualities there would be no suffering or evil in the sense of discord. But since unnecessary triviality is also evil the question of

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[31]Ibid., pp. 72-74.

whether God is indictable is really whether the positive values enjoyed by higher forms of actuality are worth the risk of the negative values. God made the choice and elected to risk discord in the quest for various types of perfection that are possible.[32]

Process theology is useful in understanding why there is so much suffering and specifically why cancer is permitted to exist. If God is Controlling Power one could question the goodness of God or deny the existence of suffering. Since God chose to increase value and intensity of experience in order to minimize triviality, the risk of discord or suffering must follow. Increased capacity for enjoyment correlates with increased capacity for suffering. Increased capacity for self-determination also correlates with increased capacity for suffering. The negative beliefs and the reluctance to assume personal responsibility by cancer patients, noted by the Simontons, highlights the use of the power of self-determination in a negative way. The Simontons emphasize the importance of attitude and belief in recovery from cancer. In the process theology view, attitudes and beliefs are important aspects in the way God can affect a person. A person who believes in God and in the effectiveness of ideal possibilities will tend to be receptive to the divine influence.

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[32]Ibid., p. 75.

## SUMMARY

This chapter presented a philosophical theological background from a Whiteheadian-process theology perspective. The mind-body problem and the problem of suffering were considered from this perspective.

# Chapter 6

## SUMMARY

Since cancer is the second ranking fatal disease in the United States and one in six die from cancer, few families are exempt from this disease. Very little attention has been given to the emotional and psychological factors involved in treating cancer patients. Traditional methods of treatment have been surgery, radiation therapy, and chemotherapy. Stress and host resistance are believed to be correlated and this has been demonstrated in animal experimentation.

Cancer is more prevalent where the following are present: depression, inability to grieve loss, high levels of defensiveness, emotional conflicts, and inability to discharge emotions in healthy ways. Loss of a major relationship often exists prior to signs of malignancy. These are certain psychological factors which appear statistically more often than in control groups. Low ego defensiveness has frequently characterized patients with fast growing tumors. It appears that too much vital energy is used in defense of an insecure ego with insufficient energy left to fight off cancer. Cancer patients are described as trying to please everyone. They are generally gentle, thoughtful, uncomplaining people, while underneath

there are feelings of unworthiness, self-hatred, and bottled-up hostility. They are unable to deal appropriately with anger and aggression.

The major predisposing factor to development of cancer found by the Simontons was the loss of a serious love object, occurring 6 to 18 months prior to diagnosis. This loss creates a feeling of helplessness and hopelessness, which suggests an inability to express grief and work through the loss.

Although we do not have complete understanding of how emotional and personality factors influence the onset and course of cancer, a pattern is emerging. It may not be possible to define a specific personality configuration that correlates directly with cancer because of the wide variety of emotional conditions that are present in cancer patients. The optimistic aspect is that psychosocial and personality factors can be changed to promote healing.

A meditation-visualization technique is used by the Simontons primarily to reduce stress and restore the body's natural ability to ward off disease through the immune system. This practice along with group meetings and intensive psychotherapy can have the effect of emotional catharsis, achievement of valuable personality insights, and motivating people to live. If psychological stress depresses immune activity, stress reduction could restore the body's ability to overcome invading viruses in those

cases where cancer is the result of a virus, or generally to attack and eliminate malignant cells.

The belief system of the patient is an important aspect in the course the body takes during and after treatment. Simonton discovered a high correlation between a positive attitude and positive response to treatment. Cancer patients often see themselves as victims of the disease and have negative feelings about treatment. They tend to see themselves as not having participated in the development of cancer which they perceive as an outside agent acting in the body, and they can do nothing personally to help themselves get well. Simonton found cancer patients have difficulty dealing with personal responsibility. Over one-half of the patients treated by the Simontons will not participate in psychotherapy or use the relaxation and visualization techniques. Cancer victims are generally characterized by a poor self-image and see cancer as synonymous with death. Simonton feels it is mandatory to modify the low self-image and negative feelings early if the course of the disease is to be modified significantly. He pointed out that the belief system of the family and the physician frequently parallels that of the patient.

Those involved in pastoral care are likewise concerned about the belief system of cancer patients. In addition to those negative beliefs noted by the

Simontons, patients frequently have feelings of guilt. They interpret their suffering as divine punishment for sins so that their theology potentiates an unhealthy state. The process theology position can be used to avoid this negative interpretation. Process theology holds that divine causality is persuasive and not compulsive. God is not the only efficient cause of any event but one of many influences. Each actuality has some power for self-determination, and thus power to choose how to respond to the various efficient causes, including God. A person's beliefs and attitudes play an important part in the way God can causally affect him. The person who does not believe in God will tend to be unreceptive to divine influence. Process theology supports the view that God is on the patient's side, that there is a divine healing power with which he can cooperate.

Process theology holds that God desires healthy cells which enjoy themselves and contribute to the enjoyment of the body and mind of the human being. It is suggested that occasional divine intervention is not the manner in which God relates. The pastor's role in this healing process is to help people find a positive health-giving belief system, one that unites rather than separates, people from God.

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